Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CORPUS CHRISTI MEDICAL CENTER
HOLLAWAY & GUMBERT
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
Box Number 01

MFDR Date Received
JANUARY 5, 2004

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M5-08-0102-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated January 2, 2004: "Please be advised our law firm has been retained by the Requestor, Corpus Christi Medical Center, in connection with its request for medical dispute resolution."

Requestor's Supplemental Position Summary Dated January 27, 2004: "On January 9, 2003, [Claimant] was admitted to the hospital directly from his doctor's office…As soon as practicable, the hospital's representatives contacted the carrier's representatives for authorization, and were led to believe that authorization would be provided upon receipt of all patient's clinical. Our client provided the necessary clinical on the patient, but was never provided an authorization number in this matter. It is our position that the hospital acted properly in seeking a pre-certification in this matter, and through no fault of their own were not provided one."

Requestor's Position Summary Dated August 21, 2008: "The attached documents state the position taken by every workers' comp insurance carrier that we have sued in District Court in connection with a First Health or other type of PPO contract. The situation is the same with several major carriers. They all contend as follows: regardless of the existence of a PPO agreement, (and even while admitting that they used to PPO for favorable payment rates), every carrier we have sued in court instead of pursuing MDR contends and files motions and briefs with the courts, taking the position that the DWC has exclusive jurisdiction over the fee dispute. The carriers go outside the WC system to contract for more favorable rates, but then maintain that providers must follow the MDR process within the DWC----even in cases where they have breached the applicable contract. Accordingly, to protect our clients' rights to judicial review, we request that DWC issue its order, stating its specific reason(s) for dismissing any claim that we have filed for MDR that the DWC believes to be outside its jurisdiction."

Amount in Dispute: $5,088.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was paid per the Texas Workers' Compensation Fee Schedule at the inpatient medical per diem of $870.00 x 1 day and then applied the ppo discount. Paid per the PPO inpatient medical per diem of $636.00 per day x 1 day. Denied 8 days stay as preauthorization was required but not requested. The facility was advised to call for preauth for services beyond the emergency admit and they were given the phone number. Liberty Mutual has no record of the facility calling for preauthorization for the continued stay. This was not a true, life threatening emergency."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2003 Through January 18, 2003	Inpatient Hospital Services	$5,088.00	$234.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective January 1, 2003, 27 TexReg 12359, requires preauthorization for non-emergency inpatient hospitalizations.
3. 28 Texas Administrative Code §133.1, effective July 15, 2000, 25 TexReg 2115, defines a medical emergency.
4. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z585 (F)-The charge for this procedure exceeds the health facility fee schedule assigned by the Texas Workers Compensation Commission.
   - Z695 (F)- The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - Z557-This contracted hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - PA-First Health Network.
   - X170-Pre-Authorization was required, but not requested for this service per TWCC Rule 134.600.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
3. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the eight subsequent inpatient hospital days based upon reason code "X170."

   The requestor contends that reimbursement is due because "As soon as practicable, the hospital's representatives contacted the carrier's representatives for authorization, and were led to believe that authorization would be provided upon receipt of all patient's clinical. Our client provided the necessary clinical on the patient, but was never provided an authorization number in this matter. It is our position that the hospital acted properly in seeking a pre-certification in this matter, and through no fault of their own were not provided one."

   The respondent continues to deny reimbursement based upon "Denied 8 days stay as preauthorization was required but not requested. The facility was advised to call for preauth for services beyond the emergency admit and they were given the phone number. Liberty Mutual has no record of the facility calling for preauthorization for the continued stay. This was not a true, life threatening emergency."

   28 Texas Administrative Code §134.600 (b)(1)(A) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or

(i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions)."

28 Texas Administrative Code §134.600 (i)(1) states "The health care requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay."

28 Texas Administrative Code §133.1(a)(7)(A) defines a medical emergency as "a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part."

The requestor has presented no evidence that suggests that preauthorization could not have been reasonable obtained after the initial inpatient hospital stay. The Division finds that the requestor has not provided any supporting documentation that preauthorization or concurrent review was sought for the disputed services in accordance with 28 Texas Administrative Code §134.600 (bi)(1)(A). As a result, reimbursement for the subsequent eight-inpatient hospital days is not recommended.

2. The insurance carrier reduced disputed services with reason codes "C" and "PA-First Health Network". Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute; therefore, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.

- 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." The length of stay was nine days; however, documentation supports that the Carrier did not pre-authorize the eight subsequent days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $870.00 for the initial day.
- 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)." A review of the submitted hospital bill finds that the requestor billed $2,311.00for revenue code 612-MRI-Spine. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 612 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

The division concludes that the total allowable for this admission is $870.00. The respondent issued payment in the amount of $636.00. Based upon the documentation submitted, additional reimbursement in the amount of $234.00 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement .

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $234.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/30/2014 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.